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Letter to the Editor

COVID virtual burns clinics — Logistical advantages and the patient perspective

2020 has brought about unprecedented changes within health services throughout the world. Organisations which have often been thought of as hierarchical, bureaucratic and slow to respond to change were asked to respond with almost no notice to dramatic changes in what was asked of them. One key, and particularly controversial aspect of this has been the postponement of elective services. In order to tackle the significant backlog of routine outpatient clinic appointments, NHS trusts have looked to virtual consultations to fill the void created by face to face clinic cancellations.

In many aspects of plastic surgery, this undoubtedly has advantages. Patients requiring simple wound reviews can be consulted with via video, post-operative patients with uncomplicated histology can be given results by telephone. As we move towards a second wave of national lockdowns and increases in COVID-19 cases, it would seem likely that the small number of elective clinics currently running face to face will be postponed. In order to prevent further backlog, hospital trusts must consider the many benefits of remote clinics again. There is no need to coordinate social distancing in waiting rooms, doctors can significantly reduce their rate of patient exposure and without the need for ancillary staff in the clinic, there are additional potential cost-saving benefits. Given these significant benefits, it would be easy to imagine that virtual clinics will eventually become a day to day part of patient care.

During the first wave of the pandemic, the burns unit at Chelsea and Westminster ran no clinics in March and April. As part of the London and South East Burns Network, receiving referrals from as far as the South East coast of the country, this clearly had a massive impact on our ability to provide burns care to these patients. In May, virtual clinics began. We ran clinics over the course of the month with 29 patients booked in for telephone or video consultations. Of these, only 2 patients were not contactable. In our units' experience, given the geographical spread of our patient group and the understandable reticence of patients to travel into central London, virtual clinics certainly held logistical advantages. At the current point in time, due to our success with virtual clinics and recognition of their limitations, the 5 burns consultants are

now running a mixture of virtual and face-to-face appointments. In November, we saw 143 patients in clinic, of which 60 were virtual. Whether or not these patients received the all-round care usually provided to burns patients remains to be seen and further patient satisfaction and outcome measures in these types of patients will be essential going into the second wave.

Burns patients represent a different, often more complex, side of plastic surgery. These patients may present with complicated psychological needs, scar management problems and long-term sequelae which cannot be easily dealt with remotely. In the literature at present, there are countless articles citing the benefits of remote consultations for doctors [1,2]. As far as we can identify, however, there has been no discussion as to whether or not burns patients' needs are met via these remote consultations. In being unable to properly examine burns scars, provide face to face psychological support and perform steroid injections are we doing burns patients a disservice with a 10-minute phone call instead? As we move into a second wave, predicted to be even more disruptive to the health service, we must urgently consider how best to manage our vast backlog of burns patients waiting for outpatient services and whether virtual clinics should remain a part of their care, long after the pandemic has left the rolling news bulletins.

Conflicts of interest

None.

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Alcohol-related burns during the COVID-19 pandemic



The World Health Organisation declared the SARS-CoV-2 virus a global pandemic on 11th March 2020, following which the British Government announced a period of restriction of personal movement on 16th March, colloquially termed “lockdown”.

The impact of the pandemic and subsequent national lockdown on individuals’ mental health has been considered by both the scientific and popular media [1,2], with a secondary focus on alcohol consumption [3]. The lockdown period resulted in a complex socio-behavioural response in the population, including changing patterns of alcohol consumption [4]. Alcohol intake in those with previous alcohol use disorders increased during this period, including those previously abstinent [5]. The association between alcohol and burn injury has previously been detailed [6,7], including the impact on burns related fatalities [8].

The effect of the United Kingdom’s COVID-19 lockdown on overall burns presentations has been considered in adults and children [9,10], in addition to the global restructuring of burns services [11]. However, there is currently a paucity of data surrounding the effect of the pandemic on alcohol-related burn injuries. We sought to establish the incidence of alcohol-related burn injuries during the COVID-19 pandemic and characteristics associated with this injury cohort.

Salisbury District Hospital Burns Unit provides specialist burn care as part of the Southwest and Wales Burn Network, accepting patients with moderate severity burns. A retrospective review was undertaken of all adult inpatient and outpatient burn injuries between 16th March 2020 and 30th September 2020 in comparison to the same period in 2019. The British Isles Burn Injury Database was used to identify patients through a comorbidity coding of alcohol abuse or a free text entry confirming the association of alcohol consumption with the burn injury.

The characteristics of each cohort are included in Table 1. The number of alcohol-related burns admissions remained similar across the two patient groups, with 5 admissions in each year. As the absolute number of admissions increased in 2020, this represented a 3% reduction in the proportion of total patients, from 10% to 7% of admissions. 2 patients were managed by the burns team as an outpatient in 2020, increasing from 1 patient in 2019. Alcohol was directly implicated in 5 burns in 2020, from 3 in 2019. Average units consumed per day was 19.2 in 2020 compared to 27.5 in 2019, however this was not documented in 23% of patients included.

Mean patient age was higher during the COVID-19 pandemic, rising from 38.2 to 55.7 years at time of injury. Total body surface area (TBSA) involved was comparable, at 6.6% in 2019 and 6.7% in 2020. Total length of stay showed a marked increase in 2020 from 20.8 days to 36.6 days.

Presentations of trauma [12] and medical conditions such as myocardial infarctions [13] reduced during the initial stages of the COVID-19 lockdown, which may be due to avoidance of high-risk activities or reluctance to seek medical attention for fear of contracting SARS-CoV-2. Despite this, our unit noted an increase in overall burns admissions in 2020 with a similar number of alcohol-related injuries during both years. The home environment is the most common location for burn injuries [14], and as individuals spent more time at home the risk of sustaining a burn-related injury increased accordingly.

Being of an older age is a risk factor for increasing alcohol consumption during the lockdown period [15], which may have contributed to the increased age noted in the 2020 cohort. This behavioural change is not unique to this pandemic, as social isolation resulting from the Fukushima nuclear disaster was considered to have been an influencing factor in the alcohol consumption increase in an elderly patient [16]. The relationship between an increased age and risk of alcohol-related burns is likely multifactorial; however, the increased vulnerability of the older population to isolation and loneliness during the pandemic is a possible contributing feature, which may be compounded by the increased degree of digital exclusion experienced by this group [17].

Due to the significant inpatient numbers expected as a result of the pandemic, many hospitals aimed to expedite inpatient discharges, with previous literature highlighting a reduction in inpatient length of stay within a general burn injury cohort [18]. Even with these efforts, our unit noted an increased duration of stay during 2020 despite similar TBSA involvement. Increased age has previously been linked to a prolonged hospital length of stay in burn injury patients [19], however the pandemic may have exacerbated this by complicating social care arrangements [20] such as housing, resulting in discharge delays in medically well patients.

Despite the consistent number of patients admitted with alcohol-related burn injuries and comparable TBSA involvement, mean patient age and duration of inpatient stay was noticeably increased during the COVID-19 pandemic and